SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Excess Loss Application-UHIC	SERFF Tr Num: UHLC-125631641	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 38842
Sub-TOI: H21.000 Health - Other	Co Tr Num: UHIAPP-AR (12/01)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Jayne Jackowski, Lynn Kaisershot	Disposition Date: 05/05/2008
	Date Submitted: 05/01/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/05/2008	
State Status Changed: 05/05/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We respectfully submit this form for your formal approval. This is a new form and is not intended to replace any forms previously filed with the Department. The form will be used for application for excess loss coverage by eligible employer groups in your state who self-fund their coverage.

If you have any questions or concerns, please contact me at 1-800-232-5432 extension 12234. My mailing address is United HealthCare Insurance Company, PO Box 19032, Green Bay, Wisconsin 54307-9032. My email address is

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Jayne_S_Jackowski@uhc.com.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst	Jayne.Jackowski@eams.com
3100 AMS Blvd.	(920) 661-2234 [Phone]
Green Bay, WI 54313	(920) 661-9861[FAX]

Filing Company Information

United HealthCare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Health
PO Box 150450		
Hartford, CT 06115-0450	Group Name:	State ID Number:
(215) 653-8046 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$50.00	05/01/2008	20050956

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/05/2008	05/05/2008

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/05/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Excess Loss Insurance Application	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UHIAPP-AR (12/01)	Application/ Enrollment Form	Excess Loss Insurance Application	Initial			AR - UHIC Stop Loss application.pdf

UNITED HEALTHCARE INSURANCE COMPANY

A Stock Company
450 Columbus Boulevard, Hartford, Connecticut

Phone: 1-800-xxx-xxxx]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by United HealthCare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: [ABC Company]
Address: (street, city, state, and zip): [1234 Any Street, Any City, USA.]
Key Contact: [John Doe] **Telephone**: [123-456-6789] **Tax ID**: [123456]

Applicant is a: ☒ **Corporation** ☐ **Labor Union** ☐ **Partnership** ☐ **Association** ☐ **Proprietorship** ☐ **Other:**
Nature of Business of the Group to be Insured: [Banking] Requested Effective Date: [1/1/2002]

Total number of eligible persons: [Employees: 25 Retirees: 0]
Are retirees covered: ☐ **Yes** ☒ **No.**

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

[Full Name of Administrator: ABC Third Party]
[Address: _____ (street, city, state, and zip): _____]
[Key Contact: _____ Telephone: _____]

[Agent or Broker: Jane Does]
[SS No. or Tax ID: 123-66-6789]
[Address: 1234 Any Street, Any City, USA]

SPECIFIC EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: [Covered Expenses Incurred from 10/1/2001 through 12/31/2002, and
Paid from 1/1/2002 through 3/31/2003.]
[Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to $50,000 per Covered Person.]

Specific Deductible per [☒ Covered Person {☐ Family}: $50,000]
Specific Percentage Reimbursable: [100%]
Maximum Specific Benefit per Covered Person: [☐ $500,000 ☒ $1,000,000 ☐ $2,000,000 ☐ Other $]

Covered Expenses Under Specific Excess Loss: [☒ Medical ☐ Stand Alone Prescription Drug Program]

{[**Common Accident Provision**: ☒ Yes ☐ No]}

Specific Premium Per Month:	[the premiums below will increase by 5% if the Access To Transplant Services Agreement is not signed]
[Employee	$
	$
	$
	$]

{Minimum Specific Premium $_____}

{[1. Specific Accommodation Reimbursement Endorsement ☒ Yes ☐ No
2. Specific Step-Down Deductible Endorsement ☒ Yes ☐ No Included in the above rates
3. Specific Terminal Liability Endorsement ☒ Yes ☐ No Included in the above rates
4. Aggregating Specific Deductible Endorsement ☒ Yes ☐ No $100,000]}

AGGREGATE EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: [Covered Expenses Incurred from 10/1/2001 through 12/31/2002, and
Paid from 1/1/2002 through3/31/2003.
Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to 15% of the Annual Aggregate Deductible.]

Covered Expenses under Aggregate Excess Loss Coverage: [☒ Medical ☐ Dental ☐ Vision
☒ Stand Alone Prescription Drug Program
☐ Other (Please Specify)]

Aggregate Percentage Reimbursable: [100%]
Maximum Aggregate Benefit: [☐ $500,000 ☒ $1,000,000 ☐ Other $]
Minimum Annual Aggregate Deductible: [$123,000 or 100% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

[**Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit**: [$

Aggregate Excess Loss Premium: $10.00 per employee per month]

{**Aggregate Terminal Liability Endorsement:** ☒ **Yes** ☐ **No** [☒ Monthly ☐ Annually $.65 per employee]}
{**Aggregate Accommodation Endorsement**: ☒ **Yes** ☐ **No** [☒ Monthly ☐ Annually $1.00 per employee]}

Monthly Aggregator Factors:					
Covered Persons	Medical	Prescription Drugs	Dental	Vision	
Employee					
					]

It is understood and agreed by the undersigned that:

a. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.

b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document [within 90 days] after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document [within 90 days], the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.

d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.

e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.

f. {The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned.}

g. [**Other: The undersigned Employer understands the rates for Specific Excess Loss Benefits includes the use of United Resource Transplant Network and has signed the Access To Transplant Services Agreement. If the Access To Transplant Services Agreement is not signed and attached to this application, the rates for Specific Excess Loss Benefits will be increased by 5%.**

h. Other:]

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:_____

Signature of Authorized Person: _____

Print Name:_____ Title:_____

Date: _____

Signature of Agent or Broker:_____

Print Name of Agent or Broker:_____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

{For applicants in Arkansas and Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:

If is a crime to knowingly provided false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.}

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125631641*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*38842*
Company Tracking Number:	*UHIAPP-AR (12/01)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application-UHIC*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice — Approved-Closed — 05/05/2008

Bypass Reason: Not Applicable

Comments:

Review Status:

Satisfied -Name: Application — Approved-Closed — 05/05/2008

Comments:

This is the form being submitted for approval. A copy is also on the Form Schedule.

Attachment:

AR - UHIC Stop Loss application.pdf

Review Status:

Bypassed -Name: Health - Actuarial Justification — Approved-Closed — 05/05/2008

Bypass Reason: Excess Loss Application

Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 05/05/2008

Bypass Reason: Excess Loss Application

Comments:

UNITED HEALTHCARE INSURANCE COMPANY

A Stock Company
450 Columbus Boulevard, Hartford, Connecticut

Phone: 1-800-xxx-xxxx]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by United HealthCare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: [ABC Company]
Address: (street, city, state, and zip): [1234 Any Street, Any City, USA.]
Key Contact: [John Doe] **Telephone**: [123-456-6789] **Tax ID**: [123456]

Applicant is a: ☒ **Corporation** ☐ **Labor Union** ☐ **Partnership** ☐ **Association** ☐ **Proprietorship** ☐ **Other:**
Nature of Business of the Group to be Insured: [Banking] Requested Effective Date: [1/1/2002]

Total number of eligible persons: [Employees: 25 Retirees: 0]
Are retirees covered: ☐ **Yes** ☒ **No.**

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

[Full Name of Administrator: ABC Third Party]
[Address: _____ (street, city, state, and zip): _____]
[Key Contact: _____ Telephone: _____]

[Agent or Broker: Jane Does]
[SS No. or Tax ID: 123-66-6789]
[Address: 1234 Any Street, Any City, USA]

SPECIFIC EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: [Covered Expenses Incurred from 10/1/2001 through 12/31/2002, and
Paid from 1/1/2002 through 3/31/2003.]
[Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to $50,000 per Covered Person.]

Specific Deductible per [☒ Covered Person {☐ Family}: $50,000]
Specific Percentage Reimbursable: [100%]
Maximum Specific Benefit per Covered Person: [☐ $500,000 ☒ $1,000,000 ☐ $2,000,000 ☐ Other $]

Covered Expenses Under Specific Excess Loss: [☒ Medical ☐ Stand Alone Prescription Drug Program]

{[**Common Accident Provision**: ☒ Yes ☐ No]}

Specific Premium Per Month:	[the premiums below will increase by 5% if the Access To Transplant Services Agreement is not signed]
[Employee	$
	$
	$
	$]

{Minimum Specific Premium $_____}

{[1. Specific Accommodation Reimbursement Endorsement ☒ Yes ☐ No
2. Specific Step-Down Deductible Endorsement ☒ Yes ☐ No Included in the above rates
3. Specific Terminal Liability Endorsement ☒ Yes ☐ No Included in the above rates
4. Aggregating Specific Deductible Endorsement ☒ Yes ☐ No $100,000]}

AGGREGATE EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: [Covered Expenses Incurred from 10/1/2001 through 12/31/2002, and
Paid from 1/1/2002 through3/31/2003.
Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to 15% of the Annual Aggregate Deductible.]

Covered Expenses under Aggregate Excess Loss Coverage: [☒ Medical ☐ Dental ☐ Vision
☒ Stand Alone Prescription Drug Program
☐ Other (Please Specify)]

Aggregate Percentage Reimbursable: [100%]
Maximum Aggregate Benefit: [☐ $500,000 ☒ $1,000,000 ☐ Other $]
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Aggregate Excess Loss Premium: $10.00 per employee per month]

{**Aggregate Terminal Liability Endorsement:** ☒ **Yes** ☐ **No** [☒ Monthly ☐ Annually $.65 per employee]}
{**Aggregate Accommodation Endorsement**: ☒ **Yes** ☐ **No** [☒ Monthly ☐ Annually $1.00 per employee]}

Monthly Aggregator Factors:					
Covered Persons	Medical	Prescription Drugs	Dental	Vision	
Employee					
					]

It is understood and agreed by the undersigned that:

a. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.

b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document [within 90 days] after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document [within 90 days], the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.

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f. {The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned.}

g. [**Other: The undersigned Employer understands the rates for Specific Excess Loss Benefits includes the use of United Resource Transplant Network and has signed the Access To Transplant Services Agreement. If the Access To Transplant Services Agreement is not signed and attached to this application, the rates for Specific Excess Loss Benefits will be increased by 5%.**

h. Other:]

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The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:_____

Signature of Authorized Person: _____

Print Name:_____ Title:_____

Date: _____

Signature of Agent or Broker:_____

Print Name of Agent or Broker:_____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

{For applicants in Arkansas and Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:

If is a crime to knowingly provided false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.}